

Transforming Urgent & Emergency Care – Discharge Management Final Internal Audit Report

April 2024

Hywel Dda University Health Board



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



Contents

Executive Summary.....	3
1. Introduction	4
2. Detailed Audit Findings.....	5
Appendix A: Management Action Plan	10
Appendix B: Assurance opinion and action plan risk rating.....	16

Review reference:	HDUHB-2324-05
Report status:	Final
Fieldwork commencement:	4 th December 2023
Fieldwork completion:	14 th March 2024
Debrief meeting:	18 th March 2024
Draft report issued:	20 th March 2024
Management response received:	5 th April 2024
Final report issued:	5 th April 2024
Auditors:	Gareth Heaven (Principal Auditor)
Executive sign-off:	Andrew Carruthers (Director of Operations)
Distribution:	Jill Paterson (Director of Primary Care, Community & Long Term Care) Alison Bishop (Urgent & Emergency Care Lead) Ceri Griffiths (Interim Assistant Director of Nursing)
Committee:	Audit & Risk Assurance Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement:

NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note:

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Hywel Dda University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Hywel Dda University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

The overall objective of this audit was to seek assurance that discharge planning and management processes in place are effective and compliant with policies and guidance.

Overview

Whilst progress was evident in the roll out of the Optimal Hospital Patient Flow Framework across a sample of wards to support the reduction in discharge delays, a number of high priority matters arising were identified including:


- no evidence of review to align discharge processes in the three counties into a single process;
- an incomplete and outdated Roll Out Action Plan; and
- incomplete and inaccurate information retained in the Frontier system.

Of the eight previous key findings identified in the last report (H DUHB-2122-34), five had not have been fully implemented.

We also identified a number of other matters for reporting and have concluded **Limited** assurance overall.

Key matters arising are summarised below with full details provided in Appendix A.

Report Opinion

		Trend
	Limited	
	More significant matters require management attention.	n/a
Moderate impact on residual risk exposure until resolved.		

Assurance summary¹

Objectives	Assurance
1 Development of a consistent discharge process aligned to national requirements	Limited
2 The implementation of the discharge process across the Health Board	Limited
3 Robust monitoring and reporting arrangement on patient discharge	Substantial

¹The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

	Objective	Control Design or Operation	Recommendation Priority
1	Discharge and Transfer of Care Policy	1 Operation	Medium
2	Discharge Disparity	1 Design	High
3	Mapping of Discharge Programmes	1 Operation	Medium
4	Roll Out Action Plan	1 Operation	High
5	Frontier System	2 Operation	High

1. Introduction

- 1.1 In 2021/22, a Discharge Planning advisory review (HDUHB-2122-34) was undertaken to assess the processes in place across the three counties within the Health Board and to ensure robust measures and controls had been established in adherence to Welsh Government (WG) guidance. A number of findings were identified to management in the report.
- 1.2 In February 2022, the WG published the *Six Goals for Urgent and Emergency Care Policy Handbook* that set out the priorities for Urgent and Emergency Care to ensure that patients get the right care, in the right place, first time.

Six Goals for Urgent and Emergency Care **Right care, right place, first time**



1. Co-ordination planning and support for populations at greater risk of needing urgent or emergency care



2. Signposting people with urgent care needs to the right place, first time



3. Clinically safe alternatives to admission to hospital



4. Rapid response in a physical or mental health crisis



5. Optimal hospital care and discharge practice from the point of admission



6. Home first approach and reduce the risk of readmission

For optimal staff and patient experience, clinical outcomes and value

- 1.3 Two key goals (Goals 5 & 6) involving discharge management whilst a key Ministerial Priorities for 2023-24 is delayed transfers of care (DTC) with the aim at reducing the backlog of delayed transfers through early joint discharge planning and coordination.
- 1.4 The potential risks considered in this review were:
- inconsistent and inefficient patient discharge processes across the three counties;
 - government guidance not adhered to in relation to managing patient discharge and hospital flow; and
 - lack of regular monitoring and assurance reporting to the Health Board.
- 1.5 The previous Discharge Processes audit review identified a number of key findings identified to enhance and strengthen the discharge process. These findings were followed up in this review.

2. Detailed Audit Findings

Objective 1: A consistent, Health Board-wide discharge process has been developed taking into account national requirements and good practice

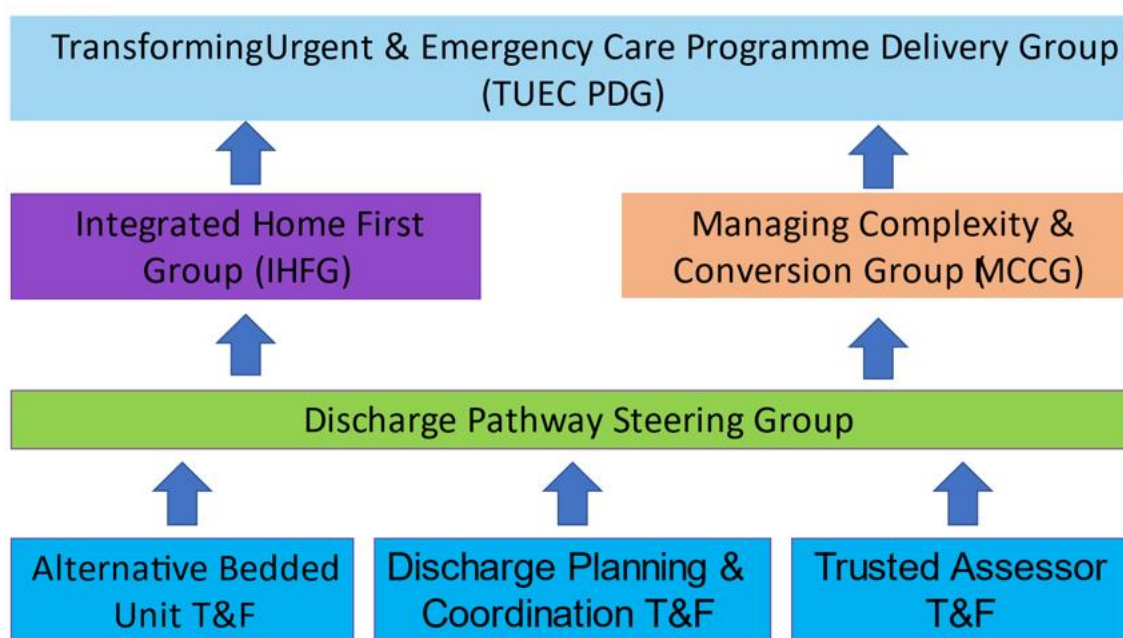
Discharge and Transfer of Care Policy

2.1 The *Discharge and Transfer of Care Adults Policy* was due for review in October 2023. Following the recent publication of the *WG National Discharge Guidance* document in December 2023, the Discharge Strategy Group noted that a review would need to be undertaken to ensure alignment with national guidance. **[Matter Arising 1]**

Governance Arrangements

2.2 The previous Internal Audit report identified the provision of health and care services differed across the three counties with a formal integrated structure and approach in Carmarthenshire, an integrated approach in Pembrokeshire and a non-integrated approach in Ceredigion. However, no review has been undertaken to align discharge processes across the three counties into a single, consistent model. **[Matter Arising 2]**

2.3 The Transforming Urgent and Emergency Care (TUEC) programme has an established governance structure with three task and finish groups feeding into the Discharge Pathway Steering Group, which subsequently reports into the TUEC Programme Delivery Board – see structure below.



2.4 A Discharge Strategy Group was also established in February 2024 to provide oversight of current workstreams and actions undertaken relating to discharge management, including Policy Goals 5 and 6, SAFER principles, clinical streaming hubs, local and national policies. The Interim Assistant Director of Nursing was named as Chair.

2.5 The Discharge Strategy Group agreed that it would not be a reporting group given the existing processes in place through the TUEC programme. A mapping exercise has been initiated to establish the numerous workstreams/ programmes, responsible officers (locally and regionally), metrics and measures. **[Matter Arising 3]**

Optimal Hospital Patient Flow

2.6 The Health Board has implemented the Optimal Hospital Patient Flow Framework that brings together key principles to support the improvement of patient flow and delivery of timely pathways of care as part of Policy Goals 5 and 6. The key principles consist of the following:

Discharge to Recovery the Assess (D2RA)	D2RA is based on the effective and timely discharge home focusing on the 'what matters' to patients through the simplification and alignment of pathways to Policy Goal 5.
Red to Green (R2G)	The R2G approach aims to reduce patients' length of stay by highlighting 'non-value' adding days and reducing avoidable delays.
Preventing Deconditioning	This principle focuses on preventing and identifying deconditioning, which can impact the patients length of stay, and promote function activities, continence management and cognitive functions.
SAFER	A good practice guide to improve patient flow and clinical outcomes through a set of rules intended to optimise patient experience and decision-making process.

2.7 The Optimal Hospital Patient Flow Framework and supporting principles was captured in a 'Ward Blueprint' document that was distributed to wards by the Quality Improvement and Service Transformation (QIST) Team as part of the phased roll out of Policy Goal 5. The 'Ward Blueprint' document provided signpost to training modules.

2.8 The Policy Goal 5 Roll Out Action Plan (Phase 1) that was developed and commenced in February 2023, captures the key actions, leads, target dates and progression status. Testing confirmed that key actions outlined in the plan, such as board round audits and the development of a deconditioning audit tool have been implemented. However, the latest plan requires updating with many actions still in progress or have not commenced. **[Matter Arising 4]**

2.9 A key element of Phase 1 Roll Out is the digital implementation of the Frontier system, which is an artificial intelligence (AI) platform that captures capacity and demand across the patient care pathways. Discussions with a sample of ward managers across Withybush and Glangwili General Hospitals and South Pembrokeshire Community Hospital confirmed that they had received training and access to the Frontier system.

Conclusion:

- 2.10 The organisation has progressed in rolling out the Optimal Hospital Patient Flow Framework and supporting key principles within wards across the Health Board. Blueprint documents have been produced with links to training modules in order for ward staff to refer to, whilst spot audits have been undertaken to identify areas of weaknesses following the roll out of the framework.
- 2.11 However, issues have been identified including the extant policy has yet to be revised, no review has been undertaken to align discharge processes across the three counties, mapping exercises have only recently been undertaken to understand and document the various workstreams and their reporting structures. We have concluded **Limited** assurance for this objective.

Objective 2: The patient discharge process has been consistently implemented across the Health Board

- 2.12 Internal Audit visited the following wards on 13th March 2024 to establish whether the Optimal Hospital Patient Flow Framework and its key principles was embedded into their patient discharge process.

Glangwili General Hospital

- Cadog Ward
- Dewi Ward
- Gwenllian Ward
- Picton Ward
- Towy Ward
- Preseli Ward

Withybush General Hospital

- Ward 1
- Ward 4
- Ward 12
- Puffin Ward

South Pembrokeshire Hospital

- Cleddau East

- 2.13 Board rounds had been undertaken with afternoon huddles also scheduled to take place on the sampled wards in line with guidance. All wards undertake daily board rounds/huddles and are regularly attended by nursing, clinical therapies and pharmacy staff, whilst some groups such as social workers, Delta Wellbeing members and discharge liaison nurses (DLNs) would attend once/twice a week. In addition to the board rounds and huddles, multi-disciplinary team (MDT) meetings would also be undertaken to discuss patient needs and actions.
- 2.14 All sampled wards maintained a patient whiteboard with consistent headings in line with the Frontier system and guidance document including the inclusion of D2RA pathway, R2G status, estimated discharge of date (EDD) and clinically optimised status. Guidance documents and posters in relation to the key principles was evident on wards. We can also confirm that a daily actions column was maintained and reviewed at the afternoon huddles to confirm the progress made.

2.15 A sample of 55 patients (from the sampled wards) was selected and their discharge information obtained from the Frontier system¹. Whilst we were provided with the status and actions for all patients sampled by Ward Managers, this information was not always recorded in the Frontier system.

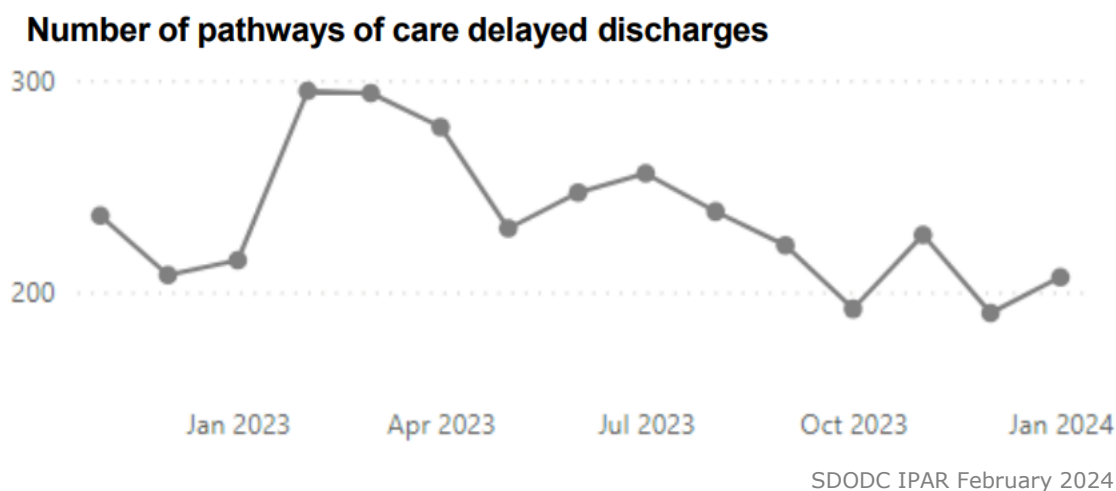
2.16 We also noted 13 instances were identified where the D2RA pathway had not been recorded on Frontier, whilst one patient’s assigned pathway required amending due to their medical circumstances. Many of the EDD recorded on the ward whiteboards also did not reconcile to the EDD in the Frontier system. **[Matter Arising 5]**

Conclusion:

2.17 The embedding of board rounds and huddles was evident within our testing, with ward whiteboards aligning to the requirements of national guidance and the Frontier system. However, the information retained in the Frontier system, such as assigned pathways or EDD, did not always reconcile to the information recorded on the whiteboards. We have concluded **Limited** assurance for this objective.

Objective 3: Robust governance arrangements are in place to monitor and report on patient discharges

2.18 The Strategic Development and Organisational Delivery Committee (SDODC) and Health Board receive regular updates on delayed discharges through the Integrated Performance Assurance Reports (IPARs). The latest position on the number of pathways of delayed care shows a reducing trend since February 2023.



2.19 Whilst the circumstances that have resulted in delayed discharge have been identified per county within the IPAR – see breakdown below – key challenges and issues remain prevalent with actions and initiatives identified for continuous improvement in the reduction of delayed discharges numbers.

¹ Report run and information extracted as at 13th March 2024 (00:00 hrs)

Reason	Resident Local Authority				Total
	Carmarthenshire	Ceredigion	Pembrokeshire	Powys	
Awaiting completion of assessment by social care	29	1	16	2	48
Awaiting completion of assessment Nursing/AHP/Medical/Pharmacy	11	10	7		28
Awaiting start of new home care package	20	2	2		24
Awaiting Social worker allocation	5	11	3	1	20
Awaiting NH availability	5	2	5		12
Awaiting reablement care package	3	4	1		8
Awaiting RH availability	4	1	1	2	8
Mental Capacity	3	1	1	1	6
Awaiting joint assessment	1	3			4
Awaiting nursing/residential home self-funding		4			4
Other	25	7	10	3	45
Grand Total	106	46	46	9	207

SDODC IPAR February 2024

2.20 The Health Board have regularly submitted monthly pathway of care delays to the WG during 2023-24.

Conclusion:

2.21 Regular reporting of discharge delays, including actions and initiatives to address the backlog was evident within the Health board and to the WG. We have concluded **Substantial** assurance for this objective.

Key findings arising from the previous internal audit report have been implemented

2.22 Previous key findings have been followed up as part of the current audit fieldwork set out under objectives 1, 2 & 3 above, with the current status summarised in the table below. New recommendations have been raised where appropriate (see Appendix A) and supersede those raised in the previous audit (H DUHB-2122-34).

Implemented	Action Ongoing	Not Implemented
3	4	1

Appendix A: Management Action Plan

Matter Arising 1: Discharge and Transfer of Care Policy (Operation)		Impact
The Discharge and Transfer of Care Adults Policy has not been reviewed since it expired in October 2023.		Potential risk of: <ul style="list-style-type: none"> inconsistent and inefficient patient discharge processes across the three counties; government guidance not adhered to in relation to managing patient discharge and hospital flow.
Recommendation		Priority
1.1	The Discharge and Transfer of Care Adults Policy should be promptly reviewed and updated in line with national guidance.	Medium
Agreed Management Action		Target Date
1.1	The Discharge Strategy Group will review and update The Discharge and Transfer of Care Adults Policy in line with recent WG National Discharge Guidance, incorporating links to the Reluctant Discharge Policy and Care Home of Choice policy.	30 th June 2024
		Responsible Officer
		Interim Assistant Director of Nursing, Operations

Matter Arising 2: Discharge Disparity (Design)		Impact	
<p>The previous Internal Audit report (HDUHB-2122-34) identified the provision of health and care services differed across the three counties with a formal integrated structure and approach in Carmarthenshire, an integrated approach in Pembrokeshire and a non-integrated approach in Ceredigion. However, no review has been undertaken to align discharge processes across the three counties into a single, consistent model.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> inconsistent and inefficient patient discharge processes across the three counties. 	
Recommendation		Priority	
2.1	A review of discharge health and care service provisions across the three counties should be undertaken and aligned into a single, consistent model.	High	
Agreed Management Action		Target Date	Responsible Officer
2.1	A review of the current discharge processes in line with the principles of optimal hospital flow will be undertaken by the TUEC Programme, QIST and the Discharge Strategy Group to identify areas of variation and to establish a single consistent model for discharge processes, recognising that each county and local authority will have some natural variation.	31 st July 2024	Interim Assistant Director of Nursing (Operations)
2.2	Review all existing discharge patient information and develop a single Discharge Patient Information Leaflet to be implemented across all acute and community sites.	30 th September 2024	Interim Assistant Director of Nursing (Operations)

Matter Arising 3: Mapping of Discharge Programmes (Operation)		Impact	
No mapping process had been undertaken to understand the current programmes of work or governance arrangements in order to identify any gaps or areas not captured.		Potential risk of: <ul style="list-style-type: none"> inconsistent and inefficient patient discharge processes across the three counties. 	
Recommendation		Priority	
3.1	A review following the planned mapping exercise by the Discharge Strategy Group should be undertaken across identified workstreams and programmes to ensure clear governance and reporting arrangements are established.	Medium	
Agreed Management Action		Target Date	Responsible Officer
3.1	Develop a flowchart of the agreed national discharge processes and pathways in line with the Discharge Requirements document and align with local variations from local authorities and third sector partners.	30 th June 2024	Urgent Emergency Care Lead
	Develop clear 'action' cards for all staff involved with discharge processes to ensure clarity of roles and responsibilities	30 th September 2024	Interim Assistant Director of Nursing (Operations)
	Undertake a review of the current discharge liaison services across the acute and community hospital sites to mitigate variation and establish core principles for service delivery	31 st May 2024	Interim Assistant Director of Nursing (Operations)

Matter Arising 4: Roll Out Action Plan (Operation)		Impact	
The latest Policy Goal 5 Roll Out Action Plan requires updating with many actions still in progress or have not commenced.		Potential risk of: <ul style="list-style-type: none"> • inconsistent and inefficient patient discharge processes across the three counties; • government guidance not adhered to in relation to managing patient discharge and hospital flow. 	
Recommendation		Priority	
4.1	The Policy Goal 5 Roll Out Action Plan should be updated with commencement and target dates adjusted where delays have occurred in order to provide an accuracy position of the implementation status.	High	
Agreed Management Action		Target Date	Responsible Officer
4.1	Review and update the Policy Goal 5 action plan and share with the Discharge Strategy Group and Managing Complexity and Conversion Group as part of the TUEC reporting structure.	30 th April 2024	Interim Optimal Flow Task & Finish Lead
	Optimal Flow Framework Lead to be agreed, Local Operational Leads to be agreed and the Optimal Flow Task & Finish Group be re-established	31 st July 2024	SRO TUEC Programme
	Local robust roll out plans to be developed & implemented by Operational teams, supported by the QIST Practitioners, to ensure consistent application of the Optimal Flow Framework across all acute and community wards.	30 th June 2024	Local Operational Leads – Optimal Flow

Matter Arising 5: Frontier System (Operation)		Impact	
<p>Whilst we were provided with the status and actions for all patients sampled by Ward Managers, this information was not always recorded in the Frontier system. We also noted 13 instances were identified where the D2RA pathway had not been recorded on Frontier, whilst one patient’s assigned pathway required amending due to their medical circumstances. Many of the EDD recorded on the ward whiteboards also did not reconcile to the EDD in the Frontier system.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> government guidance not adhered to in relation to managing patient discharge and hospital flow. 	
Recommendations		Priority	
5.1	Ward staff should ensure the Frontier system is promptly and accurately updated to reflect the patients’ status as maintained on the whiteboards.	High	
5.2	An audit of the Frontier system should be undertaken to establish whether the data is complete and accurately reflects patients status on the ward. Where issues are identified, consideration should be given to establishing the circumstances and implementing actions to address any issues, such as additional training.	Medium	
Agreed Management Action		Target Date	Responsible Officer
5.1	Operational Management Teams to meet with QIST Practitioners to agree local communication / engagement plans ensuring all ward staff are aware of the importance of ensuring that the Frontier system is updated in a timely manner to ensure accuracy of data being collected.	30 th June 2024	Local Operational Leads – Optimal Flow
	A review of potential WIFI connectivity issues limiting access to Frontier in some clinical areas to be completed and shared with the Managing Complexity Group and escalated as required.	31 st May 2024	Interim Optimal Flow Task & Finish Lead

5.2	Regular (bi-monthly) spot audits to be implemented by Senior Nurse Managers in clinical areas using Frontier to review compliance and accuracy with capturing data including EDD, D2RA Pathway and R2G.	30 th June 2024	Interim Assistant Director of Nursing (Operations)
-----	---	----------------------------	--

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)